

# Clear Communication Works – Medical Provider Referral Form

Patient Name:

Date of Birth:

Phone/Email:

Parent/Guardian:

Reason for Referral:

Referring Provider:

Practice Name:

Phone:

Fax:

Email:

Additional Notes:

## **Airway & Voice**

Airway & Voice Evaluation

Chronic Cough/PVFM/ILO

Muscle Tension Dysphonia

Vocal Fatigue/Strain

Vocal Hygiene Counseling

Stress-Related Laryngeal Tension

## **Orofacial Myofunctional Therapy**

Myo Evaluation

Tongue Posture/Low Resting Posture

Mouth Breathing

Tongue Thrust/Swallowing Pattern

Oral Habit Elimination

Pre-Frenectomy Therapy

Post-Frenectomy Therapy

Sleep-Related Myofunctional Therapy

TMJ-Adjacent Support

## **Sleep & Breathing**

Snoring/Sleep-Related Breathing Concerns

Nasal Breathing Training

Airway Pattern Retraining

## **Functional Communication**

Communication Anxiety/Selective Mutism

ADHD-Related Communication Support

Social-Pragmatic/Functional Communication

Provider Signature:

Date: